Grant County
P O Box 37
Ephrata WA 98823
(509) 754-2011

WAIVER OF COVERAGE

1. EMPLOYEE INFORMATION			
Employee Name	Social Security #	Gender ☐ Male ☐ Female	Date of Birth

2. WAIVER CONFIRMATION

This is to confirm that I decline to participate in the Grant County Medical and or Dental benefits program offered through their group health plan as follows:

☐ I do not wish to enroll **myself.** I have other Group coverage as follows:
- ☐ CHAMPUS/Tricare.
- ☐ Medicare as primary, at the request of the Medicare enrollee.
- ☐ Another group health plan through my spouse or parent.

☐ I do not wish to enroll **myself.** I have other individual coverage.

☐ I do not wish to enroll **myself.** I do not have other health coverage.

☐ I do not wish to enroll my ☐ Spouse ☐ Children* They have other Group coverage.

☐ I do not wish to enroll my ☐ Spouse ☐ Children* They have other individual coverage.

☐ I do not wish to enroll my ☐ Spouse ☐ Children* They do not have other health coverage.

* Please list the names of specific children you wish to waive if you are not enrolling all of them: _____

3. EMPLOYEE SIGNATURE

If you are declining enrollment for yourself or dependents (including your spouse) because of other health care coverage, you may in the future enroll yourself or your dependents in this plan prior to the next open enrollment period. To do this, you must have involuntarily lost your other coverage and we must receive your enrollment application within 30 days after your other coverage ended. Additionally, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and dependents, provided we receive your completed enrollment application within 30 days after the marriage, birth, adoption, or placement for adoption, unless a different time limit has been specified in your benefit booklet.

By signing below, you understand that you will be unable to obtain coverage under Grant County's group help plan until the next open enrollment period, unless you and/or your dependents qualify for enrollment under the special enrollment rules described above.

X	Date

Please note: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Sent to Accounting: _____